THE ASSESSMENT OF SOCIAL FUNCTIONING AT CENTRAL STATE HOSPITAL, PETERSBURG, VIRGINIA

A THESIS

SUBMITTED TO THE FACULTY OF ATLANTA UNIVERSITY

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR

THE DEGREE OF MASTER OF SOCIAL WORK

BY

LYLE MASON JONES

SCHOOL OF SOCIAL WORK

ATLANTA, GEORGIA

JUNE 1963

2a
36

ACKNOWLEDGEMENTS

My sincere appreciation to the staff at Central State Hospital for their cooperation, especially Mrs. Mildred C. Boone, Chief of the Social Service Department: to Mrs. Barbara I. Whitaker, whose constructiove criticisms helped to make the completion of this work possible.

DEDICATION

This is dedicated to my wife, Virous, and my daughter, Karen, who are the inspiration for all that I am able to accomplish.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

Significance of the Study

This study, which was planned by the social work students at the Atlanta University School of Social Work, Class of 1962, was designed to test a model for the assessment of social functioning. The model was prepared by the Human Growth and Behavior and the Research Committees of the Atlanta University School of Social Work.

Assessment is important in all social work in that there is a need to study factors which contribute to the evolvement of a problem and further the defining of the problem. It has been explicitly stated in the literature that there is a recognized need for a conceptual scheme or model to be used in the practice as one attempts to understand the individual.[1] In order for the individual to be understood, an assessment must be made.

The kind of model of assessment referred to in this study involves the construction of a symbolic record for reaching decisions. It may be seen as a way of stating a theory in relation to specific decisions. It may be seen as a way of stating a theory in relation to specific observations rather than hypotheses... "The model structures the problem. It states (or demonstrates) what variables one expected to be involved." [2]

One reason which was explicated for such a model was that a system of classification of problem entities would lay the groundwork for the construction of a network of treatment approaches. These approaches might be related,

---

[1] Helen Perlman, "The Social Casework Method in Social Work Education," Social Service Review, XXXIII (December, 1959), p. 424.

[2] Martin Loeb, "The Backdrop for Social Research," Social Service Theory and Social Work Research (New York, 1960), p. 4.

in a broad manner, to specific problem situations.[1]

In reviewing the literature, we have observed terms which, though not identical, have elements of assessment, namely, the identification and evaluation of the problem. To illustrate:

> In casework "diagnosis" is often utilized. It is defined as "a conclusion", a picture, made up of all the available facts fitted together within a particular frame of reference for particular purpose concerning itself with social and psychological facts.[2]

In this definition, a conclusion or picture can be equated with the identification of the problem; the studying of all available facts and fitting them together within a particular frame of reference for a purpose can be viewed as evaluation.

In community organization the term "community diagnosis" is employed. It involves receiving a body of factual material and identifying unmet social needs.[3] This, too, contains an element of assessment in that receiving is a process of evaluation.

In group work "evaluation" is utilized and defined as

> "that part of Social Group Work in which the worker attempts to measure the quality of a group experience in relation to the objective and function of the agency. It calls for the gathering of comprehensive evidence of individual member growth.[4]

Although this definition does not make clear the identification of the problem, it implies the study of the nature of the individual's functioning in a

---

[1] Shirley Hellenbrand, "Client Value Orientations: Implications for Diagnosis and Treatment," Social Casework, XLII (April, 1961), p. 242.

[2] Leontine Young, "Diagnosis as a Creative Process," Social Casework XXXVII (June, 1956), p. 257.

[3] Wayne McMillen, Community Organization for Social Welfare (Chicago, 1945), pp. 241-250.

[4] Harleigh Trecker, Social Group Work (New York, 1955), p. 217.

group. Studying is in keeping with our concept of the aspects of assessment.

In this final illustration, we see the importance of family diagnosis and treatment in the field of social work.[1]

> This concern does not displace the important concepts of individual dynamics, but it actually adds other dimensions to the assessment of the individual as he reacts with others. In family diagnosis, consideration must be given to (1) the specific stress that the family may be confronted with; (2) the capacities and disturbances of individual members; (3) the nature of family interaction; and (4) the social goals of the individual and the family at the particular stage of development and influence of the culture and sub-culture.[2]

The components of assessment are obvious in this statement. This the viewpoint of one author who writes frequently on the subject. Reference has also been made to the need for a family assessment model.[3]

Other terms that are utilized in social work which include components of assessment are: Study, assessment; study-diagnosis, analysis; social history, anamnesis; family, diagnosis, programming; psycho-social diagnosis, fact-finding.

Thus, the variety of terms used in social work to describe the same process reflects the need for a theoretical frame of reference or model for making assessment of social functioning.

For the purpose of this study, assessment is defined as the identification and evaluation of those socio-cultural and individual factors in role performance which make for social dysfunction as well as adequate social functioning.

---

1 Otto Pollak and Donald Brieland, "The Midwest Seminar on Family Diagnosis," Social Casework, XLII (July, 1961).

2 Otto Pollak, "A Family Diagnosis Model," Social Service Review, XXXIV, (1960), p. 19.

3 Ibid.

Purpose

The purpose of this study was to test a model of assessment of social functioning prepared by the Human Growth and Behavior and Research Committees of the Atlanta University School of Social Work by investigating what data were included in social work assessment by studying agency records.

More specifically, this study was designed to ascertain to what extent assessment information obtained by various agencies corresponded with the factors in the model.

Method of Procedure

The beginning phase of this study was carried out through the participation of second-year students of this school, during their six-month block field placement from September 5, 1961 through February 27, 1962. This writer gathered the data for the study while employed at Central State Hospital in Petersburg, Virginia, during the same period of time. The data used in this research were gathered from the records of the various agencies by students who were in advanced field work.

A sample of twenty case records was decided upon in order to allow the student ample time with which to become familiar with agency's policies and procedures and thoroughly examine the records. This was based on the assumption that this number of cases would give an idea of agency's current method of assessing social functioning for a given year. It was recognized that the sample would be more representative of social functioning assessment in small agencies than in agencies with larger loads.

Interval sampling was used for this specific research project. An alphabetical list was made of the patients who were discharged from the Security Service between June 1, 1960 through May 31, 1961. The total number was 47

less 5 cases for the pilot study, leaving a field of 42 cases. Using the formula $K-\frac{N}{n}$ the sample interval was 2 which gave a sample of 20 case records.

Upon returning from advanced field placements in March of 1963, this writer, along with the twenty-six students participating in this project, and the Research Team, of the School of Social Work, met jointly. The purpose of this was to develop classifications for the various factors included in the schedule. This was done in order to lend more uniformity to the procedure in preparing the material included in Chapter Three.

The categories were selected and each student classified the excerpts, which had been gathered in the study, in accordance to the way that it applied to the particular case. This material was shown in simple tables in Chapter Three together with definitions of the concepts, an analysis of the data, and sample excerpts for each item.

Further analysis of the schedule content was required in addition to the one related to theory appearing in chapter three. In order to accomplish this, the following points were applied to each item in the schedule: Incidence of data, Person discussed in the excerpt, location of data in the record, stage in agency contact when information was obtained, origin of data (information obtained by), source of data (data obtained from), breadth of data (number of sources of information), and datum or interpretation. Statistical tables on the eight points were set up, an interpretation of these tables and an analysis of the schedule was made. This information comprises the material found in Chapter Four.

Scope and Limitations

The study was conducted by gathering data from agency records having to do with the rendering of social services. It was specified that the data

gathered should come from records closed within a one year span, June 1, 1960 - May 31, 1961. This period of time lessened the number of records to be considered and gave a sample of the agency's current method of assessment. To further lower the number, the cases selected were taken from a specific area of the hospital, namely, the Security Service.

Some limitations of the study are (1) the researchers were students and therefore may not have been entirely familiar with the total process; (2) the number of agencies sampled is small and may not be representative of all agencies in the United States; (3) the agencies were not randomly selected; and (4) the way in which the records were written did not necessarily lend themselves to a research project of this nature.

CHAPTER II

DESCRIPTION OF THE SETTING

The origin, growth and development of Central State Hospital presents, if not a unique, at least a most interesting chapter in the history of the care and treatment of the mentally ill in this country. The seeds of its origin were sown many years prior to the actual beginning of the care and treatment of patients, which did not take place until immediately following the secession of hostilities in the War between the States during April of 1865.[1]

During its organizational meeting in Philadelphia, Pennsylvania in October of 1854, the American Psychiatric Association appointed a committee to study and report on the status of institutional care for mentally ill Negroes. Doctors Francis T. Stribbling and John M. Gault, superintendents of state asylums in Virginia and Doctor William N. Awl of Ohio were members of the committee. They were strong in their recommendations that every effort be made to expand the facilities available to the "insane colored."

During the next few years very little was done in the way of progress. This was due to advent of the Civil War. It was not until just before the close of the war, March 3, 1865, that Congress created what was known as the "Freedman's Bureau" of the United States War Department to last one year, but a later act of Congress continued it until 1872. The primary mission of this bureau was to distribute rations and supplies among the Negroes. In the summer of 1865 an operation was begun for the care and treatment of sick and homeless Negroes. This was the Howard Grove Hospital which was situated in a

---

[1]T. G. Denton, M.D. (ed.), "Central State Hospital, 1865-1960" (Commonwealth of Virginia Department of Mental Hygiene and Hospitals, 1960), p. 1. (Mimeographed.)

frame building previously a Confederate State Hospital. In 1868 this hospital under the control of the State of Virginia took care of sick incapaciated Negroes of all sorts, including those who were "insane and feeble-minded."

Central State Hospital is the oldest institution of its kind established exclusively for Negroes. Only four states have established such institutions.

> Virginia, in 1869; North Carolina, in 1875; Alabama, in 1908, and Maryland in 1912. At no time, however, have insane Negroes been cared for in the same wards with white insane. In southern states where there is no separate institution for the Negroes they are cared for at the state institute in buildings set apart exclusively for them.[1]

in 1845, when there was no separate institution, 15 mentally ill Negroes were cared for in basement rooms at the asylum at Williamburg, Virginia. As early as 1774, "free-born" Negroes were admitted to the asylum at the colonial capital. In 1846 the Virginia legislature passed a bill authorizing that asylum to receive mentally ill slaves, however they could not be accepted in preference to any white person.

In 1863, the mentally ill Negroes of Virginia were cared for in separate buildings at the asylum in Williamburg. By 1862 there were 40 such patients and as mentioned before, the Civil War put a stop to efforts to establish a state institution for Negroes. However, a few years later the movement was revived.

"On December 17, 1869, Major General Conby, Military Governor of Virginia declared Howard Grove Freedman's Hospital, a Confederate States Hospital, an asylum exclusively for the colored insane.[2] The Negro patients being kept at

---

[1] Ibid.

[2] The Institutional Care of the Insane in the United States and Canada, vol. III. (Baltimore, Maryland, 1916) p. 740.

Williamsburg were transferred to this hospital. On June 7, 1870 the General Assembly of Virginia passed an Act incorporating the "Central Lunatic Asylum as a regularly organized state institution, located temporarily at Howard Grove near Richmond, for the reception and treatment of colored persons of unsound mind." [1] The Board of Directors, eight white men and three Negroes, was headed by Dr. Hunter McGuire, a famous Richmond surgeon. The first superintendent of this institution was Dr. Donue B. Conrad. In his first report to the Board of Directors, he indicated that the facilities were primitive and consisted mainly of two wooden buildings and fifteen acres of land. Sanitary, cooking, laundry, storage and maintenance facilities were practically nonexistent. [2]

In the next three years approximately $30,000 was spent on structural improvements. Buildings were constructed to improve operational facilities and some increases were made in bed capacity.

During the year of 1875, Dorothea Dix, who had done so much for the humane care of the insane throughout the country, honored this institution by a visit and gave, for the benefit of the patients, a number of pictures and musical instruments.[3] Through the fifteen years that the hospital remained at Howard Grove there were many changes that took place because of political upheavals and also as a result of the outlook in the care of the mentally ill. In 1876 Dr. Randolph Barksdale, then the superintendent, called special attention the "rapid" increase of the disease of insanity among the colored peoples of the

---

[1] Ibid.

[2] T. G. Denton, M.D., op. cit., p. 2.

[3] The Institutional Care of the Insane in the United States and Canada. vol. III. The John Hopkins Press (Baltimore, Md., 1916) p. 745.

state. (A review of the available literature on this subject indicates that the increase was due more to an increased cognizance of the problem, rather than an actual increase in the number of psychiatrically ill Negroes and to the inadequate capacity of the hospital to accomodate the increased demand.) [1]

In 1881 Dr. J. H. Cabell, president of the Board, and Dr. Barksdale, the superintendent, made a concerted effort to influence the legislature to appropriate the necessary funds for a permanent site. A political upheaval, with the "Readjusters" in power, occurred in the two years that followed, but even so, an act of March 6, 1882 provided for the construction of a permanent institution and appropriated the sum of $2,000 for building plans and $100,000 for their construction. On March 9, 1882 the Readjuster Board was selected consisting of 7 whites and 4 Negroes. Josiah Crump, a Negro, was elected vice-president. Dr. David F. May, a general practitioner of Petersburg, was appointed superintendent and Drs. Ferguson and Tancil, both Negroes, were appointed assistant physicians. The Board of Directors finally selected the Mayfield or Whitworth farm in Dinwiddie County, just west of Petersburg amidst historic battlefields of the Civil War and containing approximately three hundred acres. The City of Petersburg purchased the property for $15,000 and deeded it to the State of Virginia on September 22, 1882. On March 15, 1884 the legislature made an additional appropriation of $65,000, and November 27, 1884 added another $12,000 making a total of $177,000. [2]

By April 1884 the political fight seemed to be resolved, so the previous board was reinstated and Dr. Barksdale was returned as superintendent. Con-

---

[1] T. G. Denton, M.D., op. cit.

[2] Ibid., p. 4.

struction that was in progress continued and the new buildings were completed by spring of 1885. The new institution was erected on the so-called Kirkbride Plan, consisting of a four-story center-section for administrative purposes, flanked on either side by a three-story wing divided into six wards. The transfer of the 373 patients from Howard Grove was completed by March 22, 1885. There were still many problems, including lack of water storage, unsatisfactory heating systems, the need of barns, fences, roads and sewage disposal systems.

Rapid development and expansion had taken place by the time of Dr. Barksdale's retirement in 1896. The patient population increased to 820 and many new buildings and facilities were added. Dr. William F. Drewery of Petersburg was the next superintendent after having been assistant physician. During his term the Central Lunatic Asylum, now known as Central State Hospital, expanded from a small, somewhat extemporaneously run institution to a large hospital providing the best medical and psychiatric care then available. A modern system of clinical charts and records was adopted by all of the state hospitals and patients were classified and assigned according to the acuteness and the type of their illness. Increasing emphasis was placed on providing each patient with competent and specialized care. Employment and diversion were deemed important for their welfare, and in 1914 an instructoress in "Diversional Occupation" was employed. The indiscriminate use of sedatives and hypnotic drugs was discontinued and the use of restraints abolished. At the end of 1915 there were 1800 patients in the hospital and by the time that Dr. Drewery resigned in 1924 the population had grown to 2,032.

Dr. Hugh C. Henry succeeded Dr. Drewery as superintendent and remained in that position until 1938. During this administration the Medical Center and

Receiving Buildings were placed into service, the first such buildings constructed in Virginia. In 1938, the patient population had reached 3,555 an average increase of more than 100 per year. Construction was authorized to keep pace with demands, but a shortage of personnel was the paramount problem. This shortage was met by the liberal use of working patients in all phases of the hospital operation but there was still an acute shortage of doctors and nurses.

The next superintendent was Dr. Meade S. Brent who served in that capacity from 1930 to 1955. During this time the population increased by 1,105 patients for a total of 4,640 patients. The most dramatic change during the administration was the modernization of state personnel practices. As an example of practice prior to the reformation, attendants were working twelve hours a day, six days a week, for a salary of $35 a month.[1]

The next seven years saw several changes in administration as well as improvements in the physical plant and the overall care of the patients. Dr. Juul C. Nielson was superintendent from 1955 to 1958 during which time he inaugurated the Open Door Policy and promoted the construction of recreational facilities. Following Dr. Nielson's resignation, Dr. J. Kenworthy Ogden, who had been Chief of Medical Services, was appointed acting superintendent until September, 1959. During Dr. Ogden's brief stay he supervised an extensive remodeling program, expanded the Open Door Policy, expanded medical facilities and therapy with tranquilizing drugs was extended throughout the majority of the hospital. Dr. Ogden resigned to return to his native Australia and Dr. Theodore G. Denton, who had been serving as Director of Training and Research,

---

[1] Ibid., p. 7.

became superintendent on October 1, 1959. Since that time the New Administration Building was put into use. Dr. Milton H. Kibbe was appointed superintendent on August 1, 1962.

The remodeling and construction program at Central State Hospital has progressed rapidly and has resulted in a considerable improvement in the quality of the quarters available to the patients, even though the overcrowding has not been alleviated appreciably. The Open Door Policy and patient activity program have been consolidated and great effort expended to make all of the forms of modern psychiatric treatment available to as many patients as possible. Central State Hospital has been approved by the American Medical Association to provide psychiatric residency training in affiliation with the Psychiatric Department of the Medical College of Virginia. The offering of this postgraduate training has made possible the augmentation of the medical staff and the consequent elaboration of sound psychiatric treatment and practices.[1] Several buildings have been erected during recent years, including the Geriatric Building (1957), and the Middle Grade Area with four units (1960). The newest building to be placed into service is the Intensive Treatment Building which is hoped to facilitate the early return of many patients to the community.

History of Social Service Department

The Social Service Department as it is today was not in existence prior to 1956. The position of Psychiatric Social Worker C. was established August 1, 1955 to provide for a chief of the department. The department officially started on March 1, 1956 with Miss Virginia Hannon, former instructor at

---

[1] Ibid.

Atlanta University School of Social Work, as Chief. Miss Hannon remained as Chief until 1958 when upon her resignation the present Chief of Social Service, Mrs. Mildred C. Boone, began service. Since that time Social Service has grown from approximately five untrained workers to a department of eighteen workers including a Chief Psychiatric Social Worker, Psychiatric Social Workers and Social Service Aides. This has been made possible by recruiting potential workers from schools of social work and encouraging untrained workers to receive the necessary training under the Educational stipend, Department of Mental Hygiene and Hospitals of the Commonwealth of Virginia. Two of the staff were on educational leave under this program.

The expanded department has taken on expanded duties. Developments have included a foster home and family care program, a work-home program and five aftercare clinics throughout the state for the benefit of those patients who have been placed on trial visit from the hospital for a period of one year.

Social Service functions as an important part of the treatment program for the patient from his entrance into the hospital until his eventual return to his home and community.

Philosophy and Method of Assessment in the Social Service Department

The social worker functions as an important part of the psychiatric team for admission, diagnosis and treatment purposes. Each is assigned duties commensurate with his training and abilities. The Social Service Aides A. perform routine social service functions in connection with admissions and separations from the hospital. At this level the worker is closely supervised through the restriction of duties to those which have become routine in admitting, furloughing or discharging, and which present no involved problems related to institutional care.

The Social Service Aide B. assembles, records and interprets social information, and provides limited casework services for individuals receiving institutional care. The worker is required to plan and perform with little or no supervision the details of a social service program for a large institution. The scope of duties and administrative policies are loosely defined by the head of the institution. The Psychiatric Social Worker A. assembles and analyzes social data and provides casework services in connection with a mental hygiene program. He is given selected assignments and relatively close supervision of plans and methods. The work is reviewed frequently while in progress. Interpretation of social factors as related to adjustment problems are closely reviewed in planned conferences.

The Psychiatric Social Worker B. provides casework services of an intensive nature as an integral part of diagnostic study and treatment program of a mental hygiene clinic or social service unit of the hospital. This worker has considerable latitude for planning and carrying out casework services. This takes into consideration the mental, emotional and social factors involved, as well as the disposition of patients or clients for treatment. The caseload includes a relatively broad range of adjustment problems and responsibility for making a thorough analysis of such social factors as home and community conditions, personality problems, and psychological forces which may be contributing to maladjustment.

The Psychiatric Social Worker C. or Chief supervises and performs casework and/or community organization activities related to the operation of a mental hygiene clinic or social service unit concerned with psychiatric patients. In a mental hygiene clinic or psychiatric social service unit, responsibility is assumed for administration, supervision of the social case work, participation

in psychotherapy, significantly contributing to the clinic's conferences on diagnostic and treatment problems, and for organizing and conducting staff development programs, for psychiatric social workers. The Chief works under the general direction of a psychiatrist or clinical director.

An effort is made to secure an adequate social history on each patient that is admitted to the hospital, and assessment begins with the formulation of the psycho-social diagnosis. The information obtained is deemed quite necessary by the medical staff in arriving at a diagnostic category. As much as possible the family is made active in the treatment program for the patient's mental and emotional condition.

The Security Service

The data for this study were gathered from closed cases in the Security Service at Central State Hospital. Since 1950, the Security Service has been housed in a single modern unit, and has been referred to as "a hospital within a hospital" because of the completeness of its facilities. All of the services of the hospital were available in this building except x-rays, and recently it has its own food service until the Hospital reverted to a central kitchen to prepare food for the entire hospital.

The Security Service was created to examine persons who are charged with crimes in the State of Virginia when there is doubt as the state of their mental condition. If treatment is required the patient is retained to receive the necessary care until such time he is able to be returned to court or to the community. Though the hospital observes an open door policy, this unit also serves as a maximum security service in special cases.

The bulk of the approximately 290 patients housed in the security building came to the hospital on court order for an observation period of 45 days. A

complete psychiatric workup is made on each patient, including medical, psychological, and social surveys. A report is made to the court within the specified time noting the condition of the patient as to whether it is felt that he is or was responsible for his actions and/or if he is able to stand trial. If the patient requires a period of treatment, a report is made to the court with a request that he be retained until such time that it is felt that he has recovered sufficiently.

The staff of the Security Service consists of a psychiatrist, a resident physician, a clinical psychologist, a psychiatric social worker and from Nursing Service, a number of psychiatric nurses and aides.

Presenting Problems

Of the twenty cases used in this study, seventeen were males and three were females. They ranged in age from twelve to fifty-four years, with the average age being 32.7 years.

Twelve of the cases were first admissions to the hospital. Eight of the cases had two or more admissions, and the greatest number of admissions being twenty-two.

One case was a penal transfer, diagnosed Ganser syndrome. The other nineteen cases were admitted on court order. Four were charged with murder and one with attempted murder. Three were admitted with problems around alcohol, and three were charged with robbery or larceny. One each had a charge of rape, attempted rape, indecent exposure, feloneous assault, maiming, being incorrigible, arson, and disorderly conduct.

Time spent in the hospital on this admission ranged from one month and twelve days to seven months and five days. The average time spent in the hospital for the twenty cases was three months and 22.4 days.

The problems involved with nineteen of the cases used in the study were diagnoses. The one case which did not fall in this category was the penal transfer, who was sent to the hospital for treatment. The problem of diagnosis called for a complete assessment of the patient's social functioning, with psychological tests and medical examination, so that reports could be made to the court as to the responsibility of charges, and/or if the patient was able to stand trial.

CHAPTER III

CONTENT ANALYSIS

In order to present a clearer picture of the study, this chapter on content analysis is an effort to classify the various excerpts, and to point to significant findings.

Personality Factors

Innate or Genetic Potential

Intellectual potential.--This has to do with the degree of adequacy to function in situations that require the use of the following mental activities: perception, i.e., conscious awareness of the relationship between events and/or objects; the ability to deal with and use symbols; the overall ability to mobolize the resources of the environment and experiences into the services of a variety of goals (problem solving); and that which can be measured by an I.Q. test.

Relating to the preceding definition, the excerpts in intellectual potential were placed in the categories listed below.

Categories	Incidence
Perception	0
Use of symbols	7
Mobilization of environmental resources	10
Tests and measurements	12
Total	29

It is pointed out above that information on intellectual potential was associated, in most cases, with tests and measurements. There were no excerpts to fall in the category of perception. This might be explained by the fact that the perception of an individual is often discussed during staffings, but is not necessarily incorporated in the written material of

the case record.

> Intellect is a function, the task of which is to receive, store up and use the so-called learned or acquired facts. The data are derived from many sources in the environment, the educational system being the richest and best organized source.
>
> The intellect's capacity to perform one or more of its functions varies from individual to individual. Apparently the capacity is inborn.[1]

Estimates of the capacity are arrived at by administering special tests to the individual. The tests and measurements referred to above were administered by a clinical psychologist, and are routinely given to the majority of the patients who are admitted to the Security Service at Central State Hospital.

Sample excerpt: "He was found to be functioning on a borderline level of intellection and had a Full scale I.Q. of 68 with verbal and performance I.Q. of 64 and 77 respectively."

Basic thrust, drives, and instincts.--These are the tendencies present or incipient at birth, to respond to certain stimuli or situations; the innate propensity to satisfy basic needs, e.g., food, shelter, love, and security.

Categories	Incidence
Motivation for attainment of goals	4
Satisfaction of psychological needs	0
Satisfaction of emotional needs	1
Total	5

Only five of the twenty cases studied contained information with reference to basic thrust, etc. Four of these excerpts were placed in the category of motivation for attainment of goals.

> When the individual is stimulated either externally or internally and such stimulation persists and evokes sustained activity, the drive is employed. Often the deprivation of a need is followed

---

[1] Leland E. Hinsie, M.D., Understandable Psychiatry, (New York, 1962), p. 336.

> by a drive state specific to that need.--Psychological needs relate to the requirements of the personality and they are learned, in contrast to biological needs, which are unlearned.[1]

The information under this heading is provided in a number of cases by the psychological tests, however, it may be obtained by the physician or the social worker.

Sample excerpt: "He is easily self-motivated and depends upon others to stimulate him. However, once he is started, there is considerable drive and stamina."

Physical potential.--This has to do with the general physical structure, size, skeleton and musculature; racial characteristics; bodily proportions, temperament; tempo; energy and activity level; resilience and resistance.

Categories	Incidence
Physical characteristics	18
Temperament	0
Energy and activity levels	0
Resilience and resistance	3
Total	21

All eighteen of the excerpts were placed in the physical characteristics category, of which three were also classified under resilience and resistance. These classifications may be explained by the fact that the excerpts, to a large degree, were descriptive in nature. In discussing this section, there have been questions as to what extent, if any, the physical characteristics inherited by the individual contribute to his behavior.

> Man's existence as a biological being in a world of people has not been overlooked by those seeking to explain why he behaves as he does. Some investigators have given primary emphasis to the nature of his physical endowment, arguing that just as he inherits physical characteristics so he may receive and pass on

---

[1] Louis S. Levine, Personal and Social Development, (New York, 1963), p. 61.

> psychological traits such as intelligence, diligence responsibility, or aggressiveness, attributing these to physical structure, to instincts, or "human nature." Some have proposed that only environmental experiences determine man's behavior. Others explain his action in terms of normality.--It is important to note that only organic substances that affect the structural characteristics of the body are transmitted from one generation to the next; there can be no direct transmission of behavior, interests, or talents as such.[1]

Sample excerpt: "The patient is a rather tall thin boy, appearing his stated age. Physical Condition: color hair, black; color of eyes, brown; weight, 148; Height, 6' 2½".

Physiological Functioning

Physiological functioning is concerned with a description of bodily function, normal and abnormal, health or illness according to the stage of development and effect it has on social functioning.

Categories	Incidence
Bodily function	15
Health - illness continuum	7
Total	22

On nineteen excerpts fifteen were classified under bodily function, while seven were classified under health-illness continuum, there of which were under both categories. The physical condition of the patient is one of the most important factors to be considered in the assessment of social functioning. Physical disability has a profound affect on the life of the individual.

> Sickness threatens, deprives, frustrates, undermines, frightens the people involved in it. The patient role makes demands on the sick and his family for changes of attitudes and shifts in the usual ways of functioning and gaining satisfaction. Social, economic, emotional functions and balances are rocked by illness. The resources to deal with it may complicate the situation. All this suggests that, as an entry point to the diagnosis of what's wrong in the family's problem-solving and why, a careful exploration of

---

[1] Ibid., pp. 20-21.

> the problem as dynamic cause may lead us with some sure direction to beginning treatment.[1]

Sample excerpt: "Physical examination revealed a blood pressure of 140/80, and a pulse of 80. The patient complains of nervousness. Otherwise, he is physically healthy. Central nervous system was grossly intact."

On admission to Central State Hospital each patient is given a complete examination, which is repeated later, due to the fact that it has been observed that it is possible to note a difference in the findings after the patient has adjusted to the setting.

Ego Functioning (Intra - Psychic Adjustment)

Identifiable patterns for reacting to stress and restoring dynamic equilibrium.--These are the adaptive or defense mechanisms. One of the major defense mechanisms is repression which refers to the exclusion of thoughts, feelings, and wishes from conscious awareness. Some others are denial, projection, displacement, compensation, reaction formation, rationalization and intellectualization.

Categories	Incidence
Adaptive mechanisms	3
Defense mechanisms	14
Total	17

Fourteen of the excerpts gathered were placed in the category of defense mechanisms, while only three were placed under adaptive mechanisms. This might have been expected due to the fact that the subjects studied were admissions to a mental hospital, and were alleged to have been conflict with themselves and society.

> The mechanisms of adaptation operate to maintain a state of maximal balance among the intrapsychic process and the

[1]Helen Perlman, "Family Diagnosis in Cases of Illness and Disability," Family-centered Social Work in Illness and Disability: A Preventive Approach, (New York, 1961), pp. 19-20.

selves.[1]

> The mechanisms of defense, concerned with the maintenance and protection of the personality, accomplish the best possible balance of the intrapsychic process and the selves by controlling or circumventing anxiety stemming from internal conflict.[2]

Sample excerpt: ..."he does not get nor is he able to offer the emotional expression so necessary for his well-being. When thrusted upon him there is the tendancy to treat them in a retaliatory fashion, compensating for the hurt he has endured."

Internal organization of personality.--This is concerned with the degree of organization of parts of personality such as id, super-ego, and ego into a whole; personality integration, e.g., flexibility vs. rigidity of ego function, capacity for growth.

Categories	Incidence
Personality (organization) integration	7
Capacity for growth - Flexibility vs. rigidity	12
Total	19

The majority of the excerpts under this heading were categorized under capacity for growth. It is shown here that the ability to grow psychologically is dependent upon multi-factors.

> The main phases of psychic growth rather uniformly are determined by, and depend upon, the main phases of physical growth. It is the child's emotional reaction and that of his family to these phases of biological growth which most closely interact to determine the child's character structure, thus shaping his social adjustment.[3]

Sample excerpt: "His personality is one lacking in vigor and intensity but dominantly influenced by extreme feelings of passivity and dependency to a helpless and non-functional degree."

---

[1]Louis S. Levine, op. cit., p. 96.

[2]Ibid,, p. 97.

[3]Alice L. Voiland and Associates, Family Casework Diagnosis, (New York, 1962), p. 60.

Degree of Maturity

The degree of maturity is judged by the adaptability to role performance in accordance with the person's physiological, intellectual, emotional being, stage of development and the integration of cultural, social and physical factors.

Categories	Incidence
Stage of development	2
Role performance	8
Total	10

Eight of the excerpt under this heading were placed in the role performance category. The role played by the individual determines the type of adjustment he has attained in society. Society determines the social position and throughout the life of the individual there is a striving to reach certain goals.

> The culture into which the child is born continues to exert a powerful influence upon his psychological development, but only as it is interpreted and enforced, first through the parents and then, with increasing significance through the child's associations outside the family. The child's developing concept of himself, his attitudes toward his own body and his own impulses, are related to the expectations held of him because of his sex by those with whom he mingles. These expectations, which are assigned to him and over which he has no control, related to the behaviors that are associated with a particular position held with respect to the other members of the social group.[1]

Sample excerpt: "The patient is quite immature and excessively dependent with a longing for oral satisfaction."

Knowledge of the role played by the patient is especially important in the study, diagnosis and treatment process. This is a prime consideration of the Security Service in carrying out its legal function for the court, a diagnosis

---

[1] Louis S. Levine, op. cit., p. 177.

and recommendation for disposition.

Self-Image

Self-image is an individual's opinion concerning himself that can be described by the objectivity with which he views himself. This includes insight, self-awareness; sense of identity as manifested by his role performance; self-confidence or sense of one's capacities; sense of meaning or purpose; philosophy of life.

Categories	Incidence
Objectivity (self-awareness or insight)	0
Sense of identity	1
Self-confidence	7
Sense of meaning	1
Total	9

Seven of the nine excerpts were placed in the category of self-confidence. There were no excerpts under objectivity. These classifications might be explained from the standpoint that the study was made on patients in a mental hospital, and that they had some form of emotional conflict. The seven excerpts which were classified pointed to a lack of self-confidence.

> In our American culture, a high premium is placed upon the normal development of initiative and self-reliance. One ill-conceived way to foster this quality is by insistence on perfectionism in school achievement, overdirection in choice of school subjects, hobbies, playmates, occupational interests. Overprotection of the child from the normal vecissitudes of life manifests itself in unfounded fears that the child will get hurt, fall into bad company, become sexually delinquent.
>
> Other practices which destroy the development of self-confidence include depreciating the child as a boy or girl, making unfavorable comparisons between children, failing to allow for the normal expressions of hostile feelings, and discounting the advantages of knowledge and learning as a means of self-realization.[1]

---

[1] Alice L. Voiland and Associates, op. cit., pp. 113-14.

Sample excerpt: This patient impresses the undersigned as being an individual with an extremely poor concept of self, feeling of inferiority...

Patterns of Interpersonal Relationships and Emotional Expressions Related Thereto

Patterns of interpersonal relationships and emotional expressing related thereto has to do with the reciprocal relationships between individual in social situations and the resulting reactions, e.g., acceptance, rejection permissiveness, control, spontaneity, flexibility, rigidity, love, hate, domination, submission, dependence, independence, etc.

Categories	Incidence
Formulation of reciprocal relationships	11
Involvement in social situations	10
Total	21

The excerpts under this heading are equally divided between the two categories, with one being placed in both. The two categories are closely related, and it is reasonable to assume that if an individual is able to form reciprocal relationships, he should be able to become involved in social situations. As might be expected, the excerpt from these patient's records had negative implications to the listed categories.

> By the nature of things, it is also obvious that most human needs can find expressions and gratification only through relationships with other human beings. This is largely true whether the need is for loving or being loved, for maintaining a realistically founded sense of self-esteem, for protecting others. For being protected, or for any other reason. All of these involve the individual in interpersonal relationships, with their many facets. As here conceived, therefore, social functioning at the dominant emotional aims which motivate individual behavior. That is to say person-to-person relationships and the interaction of groups inevitably reflect the sensitivities and predispositions contained within the personality structure of the individual involved.[1]

---

[1] Ibid., p. 300.

Sample excerpt: Free-floating anxiety has made him maintain a great distance in dealing with people. Thereby, he does not get nor is he able to offer the emotional expressions so necessary for his well-being.

Internalizations of Culturally Derived Beliefs Values, Activity-Patterns, and Norms

This concept, which is self-explanatory, may be further defined by stating that the reference is in the form of attitudes and behavior.

Categories	Incidence
Acceptance - rejection (attitudes)	3
Conformity - non-conformity (behavior)	3
Total	6

The excerpts in this area were equally divided between the two categories. This is a small sample, but the relatedness of the two categories might have indicated like indicated like incidence. Though it is the behavior of the individual that is first seen, in assessment an effort is made to find out the whys of this behavior. This is particularly true in the process of arriving at accurate diagnoses.

> The fundamental ideology of a society role rarely changes unless the social structure is also altered. Thus, ideals and customs intrinsic to the organization of society constitute the fabric of social life, the actual basic values and standards by which people live. These may be modified and reinterpreted under the stimulus of new knowledge, events and a variety of factors. The specific form in which they are expressed will also vary with the individual, at any time, in any culture.[1]

Sample excerpt: ..."The patient is likely to adjust to new situations in terms of his previous situations, as indicated by his acting, the way he did on a farm, in a crowded city."

---

[1] Ibid., p. 34.

Socio-Cultural Factors

Cultural Derivations

Beliefs and values.--Beliefs are concerned with the prevailing attitude or conviction derived from the culture which may have evolved rationally or non-rationally and is accepted without critical reasoning. Such beliefs determine an individual's thinking about feeling, customs, and patterns of behavior, etc.

Values hve to do with the believed capacity of any object to satisfy a human desire; any object (or state of affairs, intangible ideal) or interest. Social values are those which are commonly internalized by members of the system or sub-system to which members conform in their behavior.

Categories	Incidence
Reasoned - unreasoned continuum	0
Implications for role performance	3
Total	3

When the information for this study was gathered, beliefs and values were treated separately. The two concepts were combined by the Research Team when the task of selecting categories was undertaken. In the case of this specific study, the writer does not feel that combining the two will alter the findings due to the fact that no excerpts were found under beliefs. There were only three excerpts under values, with all three falling in the category of implications for role performance. The relative absence of material in both areas is not indicative of non-importance. As mentioned earlier, these areas are also discussed, but the material is not necessarily placed in the case record. There is much material to support attention to these areas in the

assessment of social functioning.

> The infant's immediate surroundings following birth include other persons of whom he only gradually become aware but who nevertheless play a significant part in his development. These persons constitute a segment of the society into which the child is born. Their personalities incorporate the heritage of the past: the members of the society. These learnings, which represent the content of the civilization, are termed the culture and are transmitted indirectly to the child through the relationships and contacts with the persons who care for him.[1]

Sample excerpt: "...his ability to appreciate cultural and human values is extremely limited."

Activity patterns.--This is the standardized way of behaving under certain stimuli or in certain interactional situations, which is accepted or regulated by the group or culture.

Categories	Incidence
Acceptable - non-acceptable continuum	8
Relationship effect on primary or secondary group relationship	2
Total	10

The majority of the excerpts under this heading were classified under acceptable -non-acceptable continuum. This might be explained by the nature of the cases included in the study. All of these cases came to the hospital on court order, and it was noted that the larger portion of these individuals had repeated conflicts with law enforcement agencies.

> In our complex society an individual must acquire considerable knowledge about behavior and attitudes that are permissible and those which are discouraged or forbidden. These learnings are communicated not only by parents, but by peer groups, schools, and law enforcement agencies, and they include knowledge of society's rules, regulations, and laws. The laws essential to the protection of health and safety are adhered to by most persons, and less explicit regulations, called folkways and mores, carry considerable weight, for they

---

[1] Louis S. Levine, op. cit., p. 132.

relate to the behaviors considered socially proper and desirable even though they are not legally enforceable.[1]

Sample excerpt: "He is said to be a constant drinker....He had been drinking constantly since 1947...."

Social Structures and Dynamics

Family.--The family is a social group composed of parents, children, and other relatives in which affection and responsibility are shared.

Categories	Incidence
Composition	19
Interactional patterns	13
Total	32

Nineteen of the excerpts were classified under family composition. Of these nineteen, twelve were placed in both categories. Attention to the composition of the family enables the caseworker to make an evaluative description of the family structure.

> Family composition denotes all persons who are members of the nuclear family group, as well as those persons living in the home who are related or nonrelated to the heads of the family by blood ties.[2]

> Sample excerpt: The patient is the third of nine living siblings, ranging in age from sixteen to three. Her relationship with the sibling group was described as satisfactory, but it appeared that she did not relate quite so well with her mother.

Educational system.--This is the social organization directed toward the realization of the socially accepted values by means of training in knowledge, attitudes, and skills.

Categories	Incidence
Attitude toward learning	2
Level of achievement and adjustment	20

---

[1] Louis S. Levine, op. cit., p. 413.

[2] Alice L. Voiland and Associates, op. cit., p. 293.

School administrative action	1
Total	23

All of the twenty excerpts were classified under level of achievement and adjustment while two were also placed under attitudes toward learning, and one under school administrative action.

> Tension, frustration, gratification - all are involved in learning. Learning is an active process. Even when the academic material to be learned is strictly symbolic, the motivation of the student, his previous experiences of success and failure, all influence his effectiveness. Thus, the intellect is not a disembodied entity, something that can be trained or developed like a muscle; rather, the intellectual life of man is to be viewed in the perspective of his total being. At the same time, man's capacity to manipulate symbols and to assign them meaning, to use language, to think, and to engage in intellectual pursuits places him in a favored position over all other species of life.[1]

The preceding points to some of the factors that go into the learning process and to some extent, the impact on the life of the individual. The classifications indicate that level of achievement and adjustment was of most concern in this study. It is interesting to note that of the two cases involving children, the excerpts contained information about attitude toward learning.

> Sample excerpt: She started school at the age of five and was in the seventh grade at the time of her present difficulty. She related that she didn't like to go to school, and that she didn't like school because she didn't like to do school work.

Peer group.--This is a group whose members have similar characteristics as to age, sex, etc., e.g., friendship groups, cliques, gangs.

Categories	Incidence
Type (structures - unstructures)	3
Interactional patterns	9
Total	12

[1] Louis S. Levine, op. cit., p. 212.

The nine excerpts which were placed in the interactional pattern category indicated that the information gathered in this study was not concerned with the type of group as much as with the ability to form peer group relationships. However the excerpt below points to both type and interactional patterns.

> The child must acquire certain learnings from his peer relations not from adults. These relationships are important in the development of his ability to work and associate with other people. The degree to which he can cooperate and compete successfully with others is related to his early associations with his classmates as well as to his experiences within the family.[1]

Sample excerpt:..."mixed well with his classmates and is quite willing to share what he has with his friends."

Ethnic group.--This is a group which is normally endogamous, membership being based on biological or cultural characteristics and traditions.

Categories	Incidence
Biological characteristics	8
Socially imposed characteristics	15
Interactional patterns	0
Total	23

The majority of the excerpts were placed in the category of socially imposed characteristics. This was done due to the prescribed racial identifications in clinical records in the State of Virginia. This identification is called socially imposed because the Negro does not refer to himself as an African, The designation of the color is also imposed, and inaccurate.

Sample excerpt: "Race: African; Color: Black"

> Among the stresses that beset the society and to which many citizens react with great emotion are those emanating from the relations between Negro and Caucasian communities.

---

[1] Ibid., p. 253.

> Repercussions of their apposing attitudes and beliefs have been felt in education, employment, and in housing.[1]

Class.--This is a horizontal social group organized in a stratified hierarchy of relationships.

Categories	Incidence
Stratification status	1
Behavioral indications	0
Total	1

There was only one excerpt with reference to class, and this was placed in the category of stratification status. It was noted that, in the case records studied, references to status are not explicitly stated. This may be explained by the fact that ..."status is not an abstract quality attributed to a person; it always has to do with social standing within prescribed roles." [2] The excerpt does not refer directly to the individual, but to the location of the home.

Sample excerpt: "The home is located in the lower middle class integrated neighborhood."

Territorial group.--This is a locality group which has developed sufficient social organization and cultural unity to be considered a regional community.

Categories	Incidence
Designation of area	1
Behaviorial indications	0
Total	1

The lone excerpt in this group was placed in the category of designation

---

[1] Ibid., p. 471.

[2] Beatrice A. Wright, Physical Disability - A Psychological Approach (New York, 1960), p. 84.

of area. It should be pointed out here that all of the case records studied contained the home address of the patient, but this writer did not record this on the schedule unless there was a reference to this in the social work section.

Sample excerpt: "He has lived in the same general area, near Gretna, all of his life. The chief money crop in that section is tobacco which he raised on a sharecropping basis."

Governmental system.--This has to do with governmental units, e.g., courts, police, various forms of government and political parties.

Categories	Incidence
Units	17
Political ideology	0
Behavioral indications	9
Total	26

Under this heading seventeen excerpts were placed in the category of units. This classification refers to some form of government agency, and in this case, either the court or law enforcement agency. All of the cases used in this study came into the hospital on court order, and approximately one half of these individuals had previous contacts with the law. It is felt that frequent contacts with the law and the courts are indicative of deviant social behavior.

> Some behaviors have been recognized and legally specified by society as being contrary to its orderly function and to the self-interests of its citizens. When the laws are violated and the offender is apprehended and convicted, he is legally defined as a delinquent.[1]

---

[1] Louis S. Levine, op. cit., p. 420.

Sample excerpt: "He has been involved with the law on a number of charges during recent years and has been in jail on several occasions."

Economic group.--This is a system concerned with the creation and distribution of valued goods and services, e.g., employment and occupation.

Categories	Incidence
Status of employment	14
Financial status	4
Behavioral indications	3
Total	21

Fourteen of the excerpts under this heading were placed in the category of status of employment. It was found that the ability of the patient to function effectively in an employment situation, plays an important part in the assessment of social functioning, at Central State Hospital.

> A man's problem may be expressed in the work situation. The conflict is often centered on employers who, he thinks, belittle him; or he may have anxiety about not doing his job well or fellings of dissatisfaction because he has not found himself vocationally.[1]

An effort is made to get full information on each patient, regardless of age, as it is pointed out in the excerpt.

Sample excerpt:"...is a minor and therefore has held no jobs...., the family has been dependent upon the Welfare Department."

Religious group.--This is the system which is concerned with symbols, doctrines, beliefs, attitudes, behavior patterns and systems of ideas about man, the universe, and divine objects, and which is usually organized through association.

---

[1]Howard J. Parad, ed., Ego Psychology and Dynamic Casework, (New York, 1958), p. 142.

Categories	Incidence
Membership or affiliation	19
Expression of beliefs	1
Behavioral indications	7
Total	27

Excerpts on religion were found in all of the twenty cases used in this study. Nineteen of these excerpts were classified under membership or affiliation, while seven also fell under behavioral indications, and one under expression of beliefs. Religion may be viewed as one of the most important instruments in the social control of man and his relationships.

> Psychologically, religion is a power which sometimes may effectively control human behavior and physiological process.
>
> It harmonizes man on the side of will and emotion with his world. It is one of the most efficient means of social control. It stimulates social habits and checks antisocial tendencies. It gives to the whole society a conception of its own sacred values.[1]

The excerpts did not only point to the presence of religious ties but also to the absence of the same.

Sample excerpt: "The patient has never been a member of any church, and refused to go until his recent illness."

---

[1] Pitirim Sorokin, Contemporary Sociological Theories, (New York, 1928), p. 666.

CHAPTER IV

Tabular Information

The material contained in this chapter consist of a statistical analysis of the excerpts gathered in this study. In order to accomplish this, each item in the schedule was applied to eight points and set up in tables. An interpretation of each table is shown here.

Table 1

The findings in Table 1 revealed very little difference in the incidence of data in Personality Factors and Socio-Cultural Factors. There were 136 entries under Personality Factors and 139 entries under Socio-Cultural Factors, with a total of 275 for the two.

All of the items under Personality Factors contained some entries, with the lowest number being five. In the second section the majority of the entries were under family, educational system, ethnic group, governmental system, economic system, and religious system. One item, beliefs, contained no data.

Table 2

Findings in Table 2 revealed that in Personality Factors the client was discussed in all instances, except for the fact that both client and relative were discussed in four instances around patterns of interpersonal relationships. Client and relative were discussed in one instance under internalizations of culturally derived beliefs, values, etc.

Under Socio-Cultural Factors the majority of the entries discussed the client, except for the fact that the client and relatives were discussed in all twenty cases under family. There were only two entries where the relative only was discussed, and they were one each under ethnic group and economic system.

Under both factors the client was discussed for a total of 236 entries. The relative was discussed in two instances, and client and relative were discussed in thirty-seven entries.

Table 3

The findings in Table 3 revealed that the greatest quantity of material under Personality Factors was located in the clinical section of the record, where the psychological and medical reports were housed. This was true in 109 instances, while the social service section had eighteen entries. Nine entries were found on the face sheet.

In the social service section there was a total of 111 entries under Socio-Cultural Factors while there were twenty-one entries from the face sheet. There were only seven entries from the clinical section of the record.

In Personality Factors the majority of the entries from the clinical section were the items intellectual potential, physiological functioning, ego functioning, and internal organization of personality. The largest number of items located in the social service section was in interpersonal relationships. In Socio-Cultural Factors the majority of the items in the social service section had to do with family, education, governmental system, economic system and religious system. Information regarding ethnic groups was located on the face sheet in the most cases.

Table 4

In Table 4, it was shown that the information in twenty-one instances was obtained at intake. In 112 instances it was obtained early, during the diagnostic work-up period. Information obtained late in the agency contact was in three instances.

Under Socio-Cultural Factors information was obtained at intake in thirty-two instances, early in agency contact in 106 instances, and late in only one case.

The totals under both factors were fifty-three instances at intake, 218 early in agency contact and late in only four cases.

Table 5

In Table 5, the findings reavealed that the largest portion of the data under Personality Factors was obtained by the psychologist with sixty-one entries. The physician was next with forty-one, while the social worker obtained the information in thirty-three instances. It may be noted that the social worker had no entries under intellectual potential. In only one instance was the information obtained by a psychologist of another agency.

Under Socio-Cultural Factors the social worker obtained the information in 111 instances, while there were only seven entries for social worker in other agency, twenty-one for the physician and no entries for the psychologist.

It was pointed out in this table that the psychologist obtained data most frequently in intellectual potential, ego functioning and internal organization of personality. The social worker obtained information most frequently on patterns of interpersonal relationships. Under Socio-Cultural Factors the social worker was the origin of the majority of the data, while the psychologist had no entries.

Under both factors the social worker originated 144 entries. The physician had sixty-two entries and the psychologist had sixty-one. Social worker other agency had seven and just one entry for psychologist other agency.

Table 6

In Table 6, findings revealed that the social worker or other professional was the source of data in a total of 162 instances under Personality Factors. Measurements were the source in sixteen entries, non-professional person in eleven cases and the client in no cases.

Under Socio-Cultural Factors it was shown that the social worker or other professional person was the source of data in the greater number of cases, 149. The client was the source in ten instances, non-professional person in twenty-nine instances.

Under both factors the client was the source in a total of ten instances, non-professional person in forty cases, and measurements in sixteen. The social worker or other professional was the source in a total of 311 instances.

The non-professional persons include the clerical staff and attendants who fill in information on the face sheets or physical examination forms. The other professional persons are the other two members of the team, the physician and psychologist.

Table 7

Findings in Table 7 revealed that under Personality Factors, in ninety-one instances statements were made by one source. In thirty-eight instances statements were made by two sources, while in only six were there three sources and in one instance four sources.

In the Socio-Cultural Factors, in eighty-nine instances statements were made by one source. In forty instances there were two sources and in ten instances there were three sources.

The total for both factors under information from one source was 180. The total under two sources was seventy-eight, and under three sources there were sixteen. There was only one instance when the information came from four sources.

Table 8

In Table 8, findings revealed that in Personality Factors there were sixty-two excerpts consisting of datum only, thirteen entries containing

interpretations and sixty-one excerpts consisting of datum and interpretation. The items under these factors consisting mainly of datum were physical potential, and physiological functioning. Those where datum and interpretation were in majority were under internal organization of personality, ego functioning, and patterns of interpersonal relationships.

In the section on Socio-Cultural Factors findings indicated 123 excerpts containing datum only, fifteen consisting of interpretations and seventeen containing both datum and interpretation. Datum only was contained in the majority instances in items, family, educational system, ethnic group, governmental system, economic system and religious system.

The total for both factors under datum only was 169, under interpretation, twenty-eight, and a total of seventy-eight under datum and interpretation.

The eight tables shown in this chapter do not by any means cover all of the facets involved in the assessment process at Central State Hospital. The interpretations of these tables do not tend to be complete, but are meant to show the significant implications in them.

TABLE 1

INCIDENCE OF DATA

Personality Factors	Total Incidence	Yes	No
Innate or Genetic Potential			
Intellectual Potential	18	18	2
Basic Thrust, Drives, Instincts	5	5	15
Physical Potential	18	18	2
Physiological Functioning	19	19	1
Ego Functioning	15	15	5
Internal Organization of the Personality	17	17	3
Degree of Maturity	10	10	10
Self-Image	9	9	11
Patterns of Interpersonal Relationships	20	20	
Internalizations of Culturally Derived Beliefs	5	5	15
Sub Totals	136	136	64
Socio-Cultural Factors			
Culture			
Beliefs			20
Values	3	3	17
Activity Patterns	9	9	11
Sub-Systems			
Family	20	20	
Education	20	20	
Peer Groups	9	9	11
Ethnic Groups	19	19	1
Class	1	1	19
Territorial Groups	1	1	19
Political Groups	17	17	3
Economic Groups	20	20	
Religious Groups	20	20	
Sub Totals	139	139	101
Totals	275	275	165

TABLE 2

PERSONS DISCUSSED IN THE EXCERPT

Personality Factors	Total Incidence	Client	Relative	Client & Relative	No Data
Innate or Genetic Potential					
Intellectual Potential	18	18			2
Basic Thrust, Drives, Instincts	5	5			15
Physical Potential	18	18			2
Physiological Functioning	19	19			1
Ego Functioning	15	15			5
Internal Organization of the Personality	17	17			3
Degree of Maturity	10	10			10
Self-Image	9	9			11
Patterns of Interpersonal Relationships	20	16		4	
Internalizations of Culturally Derived Beliefs	5	4		1	15
Sub Totals	136	131		5	
Socio-Cultural Factors					
Cultural Derivations					
Beliefs					20
Values	3	3			17
Activity Patterns	9	7		2	11
Sub-Systems					
Family	20			20	
Educational System	20	20			
Peer Groups	9	8		1	11
Ethnic Group	19	18	1		1
Class	1	1			19
Territorial Group	1	1			19
Governmental System	17	16		1	3
Economic System	20	14	1	5	
Religious System	20			3	
Sub Totals	139	105	2	32	
Totals	275	236	2	37	

TABLE 3

LOCATION OF DATA

Personality Factors	Total Incidence	Clinical Record	Social Work Record	Face Sheet	No Data
Innate or Genetic Potential					
Intellectual Potential	18	18			2
Basic Thrust, Drives, Instincts	5	5			15
Physical Potential	19	9	1	9	1
Physiological Functioning	18	16	2		2
Ego Functioning	15	13	2		5
Internal Organization of Personality	17	17			3
Degree of Maturity	10	10			10
Self-Image	9	7	2		11
Patterns of Interpersonal Relationships	20	11	9		
Internalizations of Culturally Derived Beliefs	5	3	2		15
Sub Totals	136	109	18	9	
Socio-Cultural Factors					
Cultural Derivations					
Beliefs					20
Values	3	3			
Activity Patterns	9	1	8		11
Sub-Systems					
Family	20		20		
Educational System	20		20		
Peer Group	9		9		11
Ethnic Group	19	3	3	13	1
Class	1		1		19
Territorial Group	1		1		19
Governmental System	17		17		3
Economic System	20		18	2	
Religious System	20		14	6	
Sub Totals	139	7	111	21	
Totals	275	116	129	30	

TABLE 4

STAGE IN AGENCY CONTACT

Personality Factors	Total Incidence	Intake	Early	Late	No Data
Innate or Genetic Potential					
Intellectual Potential	18		18		2
Basic Thrust, Drives, Instincts	5		4	1	15
Physical Potential	19	12	6		2
Physiological Functioning	18	7	12		1
Ego Functioning	15		15		5
Internal Organization of Personality	17	1	16		3
Degree of Maturity	10		10		10
Self-Image	9		9		11
Patterns of Interpersonal Relationships	20	1	18	1	
Internalizations of Culturally Derived Beliefs	5		4	1	15
Sub Totals	136	21	112	3	
Socio-Cultural Factors					
Cultural Derivations					
Beliefs					20
Values	3		3		17
Activity Patterns	9	1	7	1	11
Sub-Systems					
Family	20	1	19		
Educational System	20	2	18		
Peer Group	9	1	8		11
Ethnic Group	19	15	4		1
Class	1		1		19
Territorial Group	1		1		19
Governmental System	17	1	16		3
Economic System	20	3	17		
Religious System	20	8	12		
Sub Totals	139	32	106	1	
Totals	275	53	218	4	

TABLE 5

ORIGIN OF DATA

Personality Factors	Total Incidence	Social Worker Agency	Other	Psychologist Agency-Other		Physician	No Data
Innate or Genetic Potential							
Intellectual Potential	18			13	1	4	2
Basic Thrust, Drives, Instincts	5	1		3		1	15
Physical Potential	19	6				12	2
Physiological Functioning	18	2				17	1
Ego Functioning	15	3		10		2	5
Internal Organization of Personality	17	2		14		1	3
Degree of Maturity	10	3		7			10
Self-Image	9	4		5			11
Patterns of Interpersonal Relationships	20	11		7		2	
Internalizations of Culturally Derived Beliefs	5	1		2		2	
Sub Totals	136	33		61	1	41	
Socio-Cultural Factors							
Cultural Derivations							
Beliefs							20
Values	3	3					17
Activity Patterns	9	8	1				11
Sub-Systems							
Family	20	19	1				
Educational System	20	19	1				
Peer Group	9	7				2	11
Ethnic Group	19	4	1			14	1
Class	1	1					19
Territorial Group	1	1					19
Governmental System	17	16				1	3
Economic System	20	17	1			2	
Religious System	20	16	2			2	
Sub Totals	139	111	7			21	
Totals	275	144	7	61	1	62	

TABLE 6

SOURCE OF DATA

Personality Factor	Total Incidence	Client	Non-Professional Person	Social Worker or Other Professional	Measurements	No Data
Innate or Genetic Potential						
Intellectual Potential	18			11	16	2
Basic Thrust, Drives, Instincts	5			6		15
Physical Potential	19		11	16		2
Physiological Functioning	18			23		1
Ego Functioning	15			24		5
Internal Organization of Personality	17			21		3
Degree of Maturity	10			13		10
Self-Image	9			10		11
Patterns of Interpersonal relationships	20			32		
Internalizations of Culturally Derived Beliefs	5			6		15
Sub-Totals	136		11	162	16	
Socio-Cultural Derivations						
Belief						20
Values	3			3		17
Activity Patterns	9	1	3	8		11
Sub-Systems						
Family	20			32		
Educational System	20	2	2	23		
Peer Group	9	4	1	9		11
Ethnic Group	19		15	6		1
Class	1			1		19
Territorial Group	1			1		19
Governmental System	17	3		32		3
Economic System	20		2	27		
Religious System	20		6	20		
Sub Totals	139	10	29	149		
Totals	272	10	40	311	16	

TABLE 7

BREADTH OF DATA

Personality Factors	Total Incidence	Number of Sources				No Data
		One	Two	Three	Four	
Innate or Genetic Potential						
Intellectual Potential	18	10	7	1		2
Basic Thrust, Drives, Instincts	5	4	1			15
Physical Potential	18	10	7	1		2
Physiological Functioning	19	15	4			1
Ego Functioning	15	7	7	1		5
Internal Organization of Personality	17	13	4			3
Degree of Maturity	10	8	1	1		10
Self-Image	9	8	1			11
Patterns of Interpersonal Relationships	20	12	5	2	1	
Internalizations of Culturally Derived Beliefs	5	4	1			
Sub Totals	136	91	38	6	1	
Socio-Cultural Factors						
Cultural Derivations						
Beliefs						20
Values	3	3				17
Activity Patterns	9	6	3			11
Sub-Systems						
Family	20	9	9	2		
Educational System	20	14	5	1		
Peer Group	9	5	3	1		11
Ethnic Group	19	17	2			1
Class	1	1				19
Territorial Group	1	1				19
Governmental System	17	7	5	5		3
Economic System	20	12	7	1		
Religious System	20	14	6			
Sub Totals	139	89	40	10		
Totals	275	180	78	16	1	

TABLE 8

DATA AND INTERPRETATION

Personality Factors	Total Incidence	Data	Interpre-tation	Data and Interpre-tation	No Data
Innate or Genetic Potential					
Intellectual Potential	18	10	1	7	2
Basic Thrust, Drives, Instincts	5	2	1	2	15
Physical Potential	18	18			2
Physiological Functioning	19	18		1	1
Ego Functioning	15	2	3	10	5
Internal Organization of Personality	17	3		14	3
Degree of Maturity	10	4	1	5	10
Self-Image	9	2	1	6	11
Patterns of Interpersonal Relationships	20	3	5	12	
Internalizations of Culturally Derived Beliefs	5		1	4	15
Sub Totals	136	62	13	61	
Socio-Cultural Factors					
Cultural Derivations					
Beliefs					20
Values	3			3	17
Activity Patterns	9	6	2	1	11
Sub-Systems					
Family	20	13		7	
Educational System	20	18		2	
Peer Group	9	3	6		11
Ethnic Group	19	18	1		1
Class	1	1			19
Territorial Group	1	1			19
Governmental System	17	13	3	1	3
Economic System	20	18	2		
Religious System	20	16	1	3	
Sub Totals	139	107	15	17	
Totals	275	169	28	78	

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

Assessment has been defined as the identification and evaluation of those socio-cultural and individual factors in role performance which make for social dysfunctioning as well as adequate social functioning. Through practice it has been found that assessment is important, in all areas of social work, in that there is a need to study the factors which contribute to the nature of problems. To this end, it has been felt that there is a need to arrive at a systematic or organized approach to the assessment of social functioning, whether study is attempted of individuals, groups, or communities.

The purpose of this study was to test a model of assessment of social functioning, prepared by the Human Growth and Behavior and Research committees of the Atlanta University School of Social Work. This was done by investigating closed agency records to see what data were included in social work assessment at Central State Hospital in Petersburg, Virginia. It was felt that this study is not complete due to the fact that there are many functions connected with assessment which were not included in the records studied, and for practical purposes, could not be placed on the schedule.

Due to the size of Central State Hospital, with some 4,800 patients, it was felt that a section of the hospital should be used to select the sample. Because of this writer's familiarity with its operation, and because of its clearly defined function, the Security Service was selected to be used in this study. The sample studied consisted of twenty case records closed within the one year span from June 1, 1960 to May 31, 1961. The cases were chosen

by an interval sample of an alphabetical list of cases closed within the prescribed time period. Nineteen of the twenty cases were sent to the hospital on court order for psychiatric examinations, while one was a penal transfer for treatment. They ranged in age from twelve to fifty-four years and were charged with crimes ranging from disorderly conduct to murder.

The findings in this study, based on the items included in the schedule, were analyzed in two ways. They were first analyzed according to the classifications developed by the participating students and the Research Team, applying theoretical documentations. The findings were then statistically analyzed showing the frequency of the excerpts under the eight points formulated by the Research Team.

Under content analysis, the findings in this study revealed that of the various factors, family, governmental system, religious system and intellectual potential showed the highest frequency in the two major categories. This tended to point out that more information was recorded under socio-cultural factors at Central State Hospital. The factors showing the lowest incidence were basic thrust, drives and instincts, internalization of culturally derived beliefs and values, class, and territorial group. Beliefs and values were combined for the purpose of analysis, but it should be pointed out that no data were gathered under beliefs. Values had an incidence of only three excerpts. This information may tend to be misleading, for under statistical analysis, the total incidence in socio-cultural factors were slightly higher than those of the personality factors. However, percentage-wise there were more excerpts under personality factors.

This study revealed that the patient was the person discussed under both factors, by a large margin. The relative alone was almost never discussed.

Under socio-cultural factors the client and relative were discussed approximately one fourth of the time.

Under personality factors the study revealed that at Central State Hospital, the psychologist originated almost twice as many excerpts as the social worker. However, when socio-cultural factors were included the social worker was responsible for more than twice the amount of information that was contributed by the psychologist. Approximately the same margin was true in relationship to the social worker and the physician.

Conclusions

As a result of this examination of the twenty cases included in the study, the writer was able to arrive at some conclusions with reference to the assessment of social functioning at Central State Hospital, Petersburg, Virginia. The Security Service, in which this study was made, is primarily interested in a diagnosis when the patient enters the hospital. An overall look at the data indicates that almost equal consideration is given to personality factors and socio-cultural factors in the study-diagnosis process. Percentage-wise the incidence in personality factors is slightly higher. This would tend to support the fact that an attempt is made to look at the total person, in arriving at an accurate diagnosis.

The information gathered pointed to the importance of the role of the social worker on the psychiatric team. This is substantiated by the fact that the social worker originated over two times the material of the other disciplines, and the greater portion of the information was taken directly from the Social Service Record. Most important, this writer feels that this study indicates that, as man never reaches a point where he is totally independent, so it is with the function of social work in any setting. The writer feels that it is

amply pointed out that no entity, whether it be medicine, psychology, or social work, would be able to perform the study and diagnosis without the cooperation of the other two. This was especially true in the setting from which the twenty cases used in this study were taken.

APPENDIXES

ASSESSMENT* OF SOCIAL FUNCTIONING: TENTATIVE MODEL

Personality Factors	Social Functioning (role performance) in Social Situations	Socio-Cultural Factors
A. Innate or Genetic Potential 1. Intellectual potential (Intelligence) 2. Basic thrust, drives, instincts 3. Physical Potential B. Physiological Functioning C. Ego Functioning (intra-psychic adjustment) 1. Identifiable patterns developed for reacting to stress and restoring dynamic equilibrium. 2. Internal organization of the personality. D. Degree of maturity E. Self-Image F. Patterns of Interpersonal Relationship and Emotional Expression related thereto. G. Internalizations of culturally derived beliefs, values, norms, activity-patterns, and the feelings appropriate for each.	Adequate role performance required: 1. Action consistent with system norms and goals. 2. The necessary skills in role tasks and interpersonal relationships. 3. The necessary intrapersonal organization. 4. Self and other(s) satisfactions	A. Cultural Derivations 1. Beliefs and values (symbol system) 2. Activity-patterns The feelings appropriate to each of the above. B. Social Structures and Dynamics 1. Family 2. Education 3. Peer groups 4. Ethnic groups 5. Class 6. Territorial groups 7. Economic groups 8. Political groups 9. Religious groups

*Assessment: The identification and evaluation of those socio-cultural and individual factors in role performance which make for social dysfunction as well as adequate social functioning.

ASSESSMENT SCHEDULE

GENERAL INSTRUCTIONS:

1. Read each question carefully and follow the specific instructions on this sheet.
2. Read the concepts and definitions on the separate sheet before answering each question.
3. Place a check mark in the space provided for "Yes" and "No". Every question must be checked.
4. Use at least one excerpt from the record to substantiate your answer for every question in which "Yes" has been checked.
5. Do not write in any other space except where provided on the schedule. Use separate sheets for long excerpts and be sure to identify the number of the question.
6. Include only excerpts pertinent to the question asked.
7. If whole sentences are not quoted, be sure to use three periods (...) to indicate that it is part of a quote. Four periods (....) are used if omissions are made at the end of a sentence.
8. Be sure to use a Number 2 pencil in filling out the schedule.
9. Write legibly.
10. Complete all items on face sheet including stating nature of problem.
11. Do not leave any question unanswered.
12. When the schedule is completed, go back over it to be sure all questions have a check and excerpt.
13. The entire schedule is to be considered confidential material.

IDENTIFYING INFORMATION

Code Number of
Case Record:_____

Name of Agency:

Agency Setting: Coder:_____ Date:_____

Name of Student Completing Schedule: Editor:_____ Date:_____

Date Schedule Completed:

Dates of Duration of Case:_____ Closed:_____

State the Nature of the Problem:

1. PERSONALITY FACTORS YES NO

A. Innate or Genetic Potential

1. Intellectual Potential _____ _____

2. Basic Thrust, Drives, Instincts: _____ _____

3. Physical Potential: _____ _____

B. Physiological Functioning: _____ _____

C. Ego Functioning (intra - psychic adjustment):

1. Identifiable patterns for reacting to stress and restorying dynamic equilibrium

_____ _____

Only the first two pages of the schedule are included here. The remaining factors used in the study were treated in the same manner as those on the preceding page.

BIBLIOGRAPHY

Books

Hinsie, Leland E. Understandable Psychiatry. New York: The Macmillian Company, 1962.

Hurd, Henry M. (ed.). The Institutional Care of the Insane in the United States and Canada. Vol. III. Baltimore: The Johns Hopkins Press, 1916.

Levine, Louis S. Personal and Social Development. New York: Holt, Rinehart and Winston, Inc., 1963.

McMillen, Wayne. Community Organization for Social Welfare. Chicago: The University of Chicago Press, 1945.

Parad, Howard J. (ed.). Ego Psychology and Dynamic Casework. New York: Family Service Association of America, 1958.

Sorokin, Pitirim A. Contemporary Sociological Theories. New York: Harper and Brothers, 1928.

Trecker, Harleigh. Principles and Practices of Social Group Work. New York: Whiteside, Inc., 1955.

Voiland, Alice L. and Associates. Family Casework Diagnosis. New York: Columbia University Press, 1962.

Wright, Beatrice A. Physical Disability - A Dynamic Approach. New York: Harper and Brothers, 1960.

Articles

Goldstein, Harris K. "Criteria for Evaluating Research," Social Casework, XLIII (November, 1962), 474-78.

Hellenbrand, Shirley. "Client Value Orentations: Implications for Diagnosis and Treatment," Social Casework, XLII (April, 1961), 163-70.

Loeb, Martin. "The Backdrop for Social Research," Social Science Theory and Social Research, Edited by Leonard Kogan, New York: National Association of Social Work, 1960, 3-15.

Perlman, Helen H. "Family Diagnosis in the Cases of Illness and Disability," Family-Centered Social Work in Illness and Disability: A Preventive Approach, Monograph VI, New York: Medical Social Work Section, National Association of Social Work, 1961.

Perlman, Helen H. "The Social Casework Method in Social Work Education," Social Service Review, XXXIII (December, 1959), 423-28.

Pollak, Otto. "A Family Diagnosis Model," Social Service Review, XXXIV (March, 1960), 19-28.

Pollak, Otto and Brieland, Donald. "The Midwest Seminar on Family Diagnosis," Social Casework, XLII (July, 1961), 319-25.

Shyne, Ann W. "Casework Research: Past and Present," Social Casework, XLIII (November, 1962), 467-73.

Young, Leontine. "Diagnosis as a Creative Process," Social Casework, XLIII (March, 1962), 111-14.

Unpublished Material

Denton, Theodore G. "Central State Hospital, 1865 - 1960," Commonwealth of Virginia, Department of Mental Hygeine and Hospitals, 1960. (Mimeographed.)